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ABSTRACT

This fact sheet provides data on the incidence of teenage suicide and describes the stressors which can lead to suicide. Suicide as a three-step process is discussed and warning signs are identified. Counseling interventions are listed and suggestions for preventive efforts by community members, mental health professionals, school personnel, peers, and parents are offered. (MCF)

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HIGHLIGHTS

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Teenage Suicide: Identification, Intervention and Prevention

The teenage suicide rate has risen to crisis proportions over the past 20 years. Between 1957 and 1975, the rate of suicide among 15 to 24 year olds tripled; among Native American adolescents, the suicide rate increased 1000% (*Teenagers in Crisis*, 1983). It is estimated that 5,000 to 6,000 teenagers kill themselves each year, and at least ten times that many attempt to do so. Because many suicide attempts go unreported or are reported as accidents, the estimated number may be as high as 500,000 per year. While females attempt suicide more often than males, at a rate of 4:1, males "succeed" more often, at the same rate (*Suicide Among School Age Youth*, 1984).

The Context of Suicide: A Stressful Environment

How do researchers interpret this phenomenon? The rising rate has been explained as a reaction to the stress inherent in adolescence compounded by increasing stress in the environment. Adolescence is a time when ordinary levels of stress are heightened by physical, psychological, emotional, and social changes. Adolescents suffer a feeling of loss for the childhood they must leave behind, and undergo an arduous period of adjustment to their new adult identity. In single-parent families, this adjustment may be even more difficult. Yet society alienates adolescents from their new identity by not allowing them the rights and responsibilities of adulthood. They are no longer children, but they are not accorded the adult privileges of expressing their sexuality or holding a place in the work force.

Our achievement-oriented, highly competitive society puts pressure on teens to succeed, often forcing them to set unrealistically high personal expectations. There is increased pressure to stay in school, where success is narrowly defined and difficult to achieve. In an affluent society which emphasizes immediate rewards, adolescents are not taught to be tolerant of frustration. Blurred gender roles can also be confusing and frustrating for teens (Rosenkrantz, 1978).

Some researchers attribute teenage suicide to the weakening of the family unit. They argue that economic and political institutions have penetrated it, reducing it to a consumer unit no longer able to function as a support system, and no longer able to supply family members with a sense of stability and rootedness (*Suicide and Attempted Suicide*, 1974). Awareness of the existing state of the world, now threatened by sophisticated methods of destruction, can cause depression which contributes to the adolescent's sense of frustration, helplessness and hopelessness (Smith, 1979). Faced with these feelings and lacking coping mechanisms, adolescents can become overwhelmed and turn to escapist measures such as drugs, withdrawal and ultimately suicide.

Identification: Suicide as Part of a Process

Contrary to popular belief, suicide is not an impulsive act but the result of a three-step process: a **previous history of problems** is compounded by **problems associated with adolescence**; finally, a **precipitating event**, often a death or the end of a meaningful relationship, triggers the suicide (McBrien, 1983). Long-term problems can include: losing a parent or close relative at a young age; coming from a family of divorce, or one in which there is much discord; being a victim of domestic violence or child abuse; or living with an alcoholic in the family. Hyperactivity or undiagnosed learning disabilities also pose serious long-term problems for adolescents. These problems can create further difficulties for the adolescent, causing social isolation and withdrawal, poor school performance and attendance, and repeated suicide attempts. The precipitating event which triggers a suicide attempt is usually a family crisis, a significant personal loss, or an upset to self-esteem (such as failing a course, losing one's place on a sports team or being fired from a part-time job). The anniversary of a loss can also evoke a powerful desire to commit suicide (Frederick, 1976).

Warning Signs

Many behavioral and verbal clues — some subtle, others more obvious — can alert the informed parent, teacher, counselor or friend to an adolescent's suicidal intentions. A teen at risk of committing suicide is experiencing deep depression, which may be indicated by loss of weight, appetite or interest in personal appearance; a change in sleeping pattern; fatigue; and feelings of hopelessness and low self-esteem. Sudden behavioral changes may occur: the youth may become disruptive, violent, or hostile toward family and friends; or unexplainably moody, suspicious, anxious, or selfish. He or she may spend a great deal of time daydreaming, fantasizing, or imagining ills, in extreme cases experiencing memory lapses or hallucinations.

Some signals should come through loud and clear: the teenager may express a desire to die, threaten to commit suicide, or inform friends of a plan. Self-abusive acts such as cutting off hair and self-inflicting cigarette burns are obvious suicidal gestures. The teen may develop a preoccupation with death and dying, make arrangements to give away prized possessions, withdraw from therapeutic help, or rapidly lose interest in once-valued activities and objects.

Intervention: Providing Psychological "First Aid"

Most youths who attempt suicide don't really want to die; they are crying out for help. There seems to be universal agreement on the manner in which to counsel suicidal teens:

1. Be non-judgmental.
2. Treat the youth's problems seriously, and take all threats seriously.
3. Do not try to talk the person out of it.
4. Ask direct questions, such as, "Have you been thinking of killing yourself?" Don't be afraid that you will be suggesting something the adolescent has not yet considered; usually your mentioning the topic is a relief.

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5. Communicate your concern and support.
6. Offer yourself as a caring listener until professional help can be arranged.
7. Try to evaluate the seriousness of the risk, in order to make the appropriate referral to a health care professional, counselor, or concerned teacher.
8. Do not swear to secrecy. Contact someone who can help the adolescent if he or she will not do it personally.
9. *Do not leave the person alone* if you feel the threat is immediate.

In a counseling situation, a contract can be an effective prevention technique. The adolescent signs a card which states that he or she agrees not to take the final step of suicide while interacting with the counselor (Ray, 1983).

Once past the crisis, follow-up is crucial, because most suicides occur within three months of the beginning of improvement, when the youth has the energy to carry out plans conceived earlier. Regularly scheduled supportive counseling should be provided to teach the youth coping mechanisms for managing stress accompanying a life crisis, as well as day-to-day stress.

Prevention

Community members, mental health professionals, school personnel, peers, and parents can play major roles in the prevention of teenage suicide. Programs that build adolescents' self-esteem and inspire a sense of inclusion in rather than alienation from society have been found to be particularly effective. Churches and other religious communities can sponsor suicide prevention programs, and engage youth in the planning and implementation of programs for aiding the elderly, working in day care centers, training peer counselors, and improving the environment. Libraries can sponsor similar programs which teens can develop, manage, and supervise themselves. Afterschool programs can be established in community centers to provide organized outings for cultural enrichment, computer training, tutoring, job counseling, sexuality counseling, crisis intervention, and/or health care. When staffed by people who care, these centers have the potential to become solid support networks for teenagers.

Mental health personnel can educate students, counselors, teachers, and others, such as nurses and religious youth group leaders, in suicide identification and prevention. They can lead crisis intervention workshops for counselors and teachers and train peer counselors in middle and high schools. They can establish suicide crisis centers with telephone hotlines, support groups, outreach teams to facilitate grief groups for families and in schools, and research facilities for further study.

School counselors can act as liaisons between the community and the school, between mental health professionals and teachers, and between suicidal teens and parents. They can also:

- Alert school officials to the seriousness of the issue.
- Sponsor staff development workshops to alert teachers to potential suicide risks.
- Present educational films to the school population.
- Offer stress management workshops to teens.
- Train peer counselors.
- Establish support groups for teens.
- Staff drop-in centers, providing a counseling atmosphere of support and acceptance.
- Construct a referral network of psychiatrists, psychologists, and social workers to contact in case of emergency.
- Arrange remedial reading courses to alleviate feelings of frustration and low self-esteem in adolescents with reading problems.
- Advocate that the school offer a wide variety of extracurricular activities to youth.
- Encourage more personalized teacher-student relationships.

Teachers play an especially important part in prevention, because they spend so much time with their students. Along with holding parent-teacher meetings to discuss teenage suicide prevention, teachers can form referral networks with mental health professionals. They can increase student awareness by introducing the topic in health classes. Students should learn how to identify those at risk of suicide, how to intervene with good listening and communication skills, and where to turn for help.

Peers are crucial to suicide prevention. According to one survey, 93% of the students reported that they would turn to a friend before a teacher, parent or spiritual guide in a time of crisis (*Teenagers in Crisis*, 1983). Peers can form student support groups and, once educated themselves, can train others to be peer counselors.

Finally, parents need to be as open and as attentive as possible to their adolescent children's difficulties. The most effective suicide prevention technique parents can exercise is to maintain open lines of communication with their children. Sometimes teens hide their problems, not wanting to burden the people they love. It is extremely important to assure teens that they can share their troubles, and gain support in the process. Parents are encouraged to talk about suicide with their children, and to educate themselves by forming study groups with other parents, or by attending parent-teacher or parent-counselor education sessions. Once trained, parents can help to staff a crisis hotline in their community. Parents also need to be involved in the counseling process if a teen has suicidal tendencies. These activities may both alleviate parents' fears of the unknown, and assure teenagers that their parents care.

It is possible, through the coordinated actions of parents, peers, school personnel, and the community at large, to reverse the growing trend of teenage suicide. Counselors can make the difference, by providing the leadership and motivation to guide the efforts of youngsters and adults.

Resource Documents

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